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ABSTRACT

Since 1983 the Health Education Authority Schools Education Unit has been providing a survey service to schools throughout the United Kingdom. The service enables a school to survey the health behavior of boys and girls at different ages. The purpose is to make the planning of programs in Health and Social Education in the schools more realistic. Health behaviors in the areas of substance use, dental care, diet, homework, jobs, leisure, medication, money, physical activity, road use, self-esteem, sharing problems, social activities, smoking, sleeping times, and television habits were examined. The 1987 sample included 18,014 students between the ages of 11 and 16 from 116 schools in England, Scotland, Wales, and Northern Ireland. The 1987 version contained a trial section of "illegal drugs" questions. This monograph presents data from the responses to three newly incorporated drug questions about friends' usage of illegal drugs, reports of being offered illegal drugs, and personal use of the drugs. Six tables present data describing percentages of students who know someone who uses illegal drugs; percentages of student reporting they had been offered drugs; personal use of drugs; incidence of being offered or using cannabis leaf; percentage of 15- and 16-year-olds who had been offered drugs; and exposure to cannabis leaf for 14- and 15-year-olds. (ABL)

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HEA Schools Health Education Unit

The Exeter data bank of health-related behaviour

Schoolchildren and drugs in 1987

JOHN BALDING

Director, HEA Schools Health Education Unit

A paper produced in response to the expressed needs of teachers and advisors connected with Drugs Education in schools

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1988

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THE HEA SCHOOLS HEALTH EDUCATION UNIT

Funded by the Health Education Authority, the Schools Health Education Unit supports health education initiatives in primary and secondary schools. It provides health topics, surveys and health-related behaviour analyses for local schools and Authorities throughout the UK.

A variety of services have been under continuous development, revision, and validation to assist the school, Health Authority, or Education Authority in its aims or both of the following:

1. To provide parents in secondary schools parents, teachers, pupils, and health care professionals on their views of priorities for a health education/personal education component within the curriculum. This is done through an enquiry method under the umbrella title of *Just A Tick*.

2. Discover the levels of behaviour of upper middle and secondary-school pupils over a wide range of health issues, including

Alcohol consumption	Hygiene
Dental care	Physical activity
Diet	Road use
Drugs	Self-esteem
Homework	Sharing problems
Hygiene	Smoking
Jobs	Social activities
Library permits	Time to bed/time up
Medication	TV, videos, etc.

This enquiry instrument, under the title of *The Health Related Behaviour Questionnaire*, is currently in its 11th version.

Our [illegible] and Health Profiles for [illegible] a year, is designed to give [illegible] of [illegible] health-related behaviour and attitudes [illegible] among teachers. Health-related behaviour [illegible] with the yearly development of [illegible]

For [illegible] the [illegible] of the [illegible] the questionnaire [illegible] [illegible] [illegible]

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The distribution of the 1987 sample, which included 18,014 pupils aged 11–16 in 116 schools. The number of pupils in each region is shown in plain type, followed by the number of schools in *italic type*.

FINDING OUT ABOUT YOUNG PEOPLE TODAY

Since 1983 the HEA Schools Health Education Unit in Exeter University has been providing a survey service to schools throughout the United Kingdom. In England, its work is supported by the Health Education Authority (HEA), and in Scotland, Wales, and Northern Ireland by funds from other statutory bodies. The service enables a school to survey the health behaviour of the boys and girls at different ages. The purpose is to make the planning of programmes in Health and Social Education in the schools more realistic. If teachers and parents have reliable information on levels of behaviour at different ages, appropriate action can be attempted at the right time.

What health behaviour information is gained?

The behaviours measured in the surveys carried out by each school include:

Alcohol consumption	**Money**
Dental care	**Physical activity**
Diet	**Road use**
Drugs	**Self-esteem**
Homework	**Sharing problems**
Hygiene	**Smoking**
Jobs	**Social activities**
Leisure pursuits	**Time to bed/time up**
Medication	**TV, videos, etc.**

Do the boys and girls answer honestly?

One essential feature of survey work like this is that the replies to the questions by the boys and girls should be absolutely honest. The method was first used in 1979 and since that time around 1 in 5 comprehensive schools throughout the United Kingdom have used it.

The method of presenting the questionnaire to classes has been under continuous review, and we have established that nearly 100% honesty can be assured when the boys and girls are convinced

1. Of the value of the exercise to their school and themselves;
2. That their teachers will not read the answers they write down;
3. That the completed questionnaires are completely anonymous.

Our level of confidence in the validity of the data is often questioned, and throughout the ten years of evolution of the questionnaire method the issue of honesty has been continuously addressed. Several characteristics of the survey method are relevant to its validity:

1. Those carrying out the survey pay for the service, and hence in their own interests pay strict attention to the details prescribed to promote validity (for example, the importance to the school and the pupils, its confidentiality, the respondents' anonymity, etc.).

2. Each supervisor completes a form describing any difficulties that arose with individual questions or the procedure. These forms are returned, with each batch of questionnaires to which they relate, to the Unit.
3. The completed questionnaires are not inspected at all in school, but are sealed and sent to the Unit. The scripts are processed there and summaries are returned to those collecting the data.
4. Many teachers take the data to the respondents as a component of classroom practice. Having the results scrutinised and debated by the boys and girls providing the information, or by their peers, is a unique feature in the methodology. It is a powerful way of checking on the validity of the responses, particularly with respect to honesty and to the levels of comprehension of the questions posed.
5. Systematic work with respondents to examine answers following their completion of the questionnaire is undertaken at intervals by the Unit staff and by other experienced interviewers. To date, more than 80 different experienced interviewers have contributed to this most important aspect of validation. The outcome of all this extensive and painstaking work has been to generate a high level of confidence in the validity of the data gathered from the use of the questionnaire. A fuller description of the type of work we have done appears on page 20, based on a somewhat diffident statement of our state of progress and level of confidence in 1984.

The sample

Results from these very large samples each year are extremely interesting, but the question posed is to what extent does each year's results reliably reflect the national picture? Where overlap between data collected in these surveys and data from other surveys (for example, OPCS, DHSS and ASH surveys) is studied, similarity in results is discovered; consistency between succeeding annual results over a wide range of behaviours is further convincing evidence of reliability.

The 1987 sample contains a total of 18,014 pupils (9611 boys and 8403 girls) between the ages of 11 and 16, in 116 schools in England, Scotland, Wales, and Northern Ireland, who completed Version 11 of the Health Related Behaviour Questionnaire in 1987. The following tables give useful information about the sample.

S

Number of schools represented

England	111
Scotland	4
Wales	1

Sex by year group

	Boys	*Girls*	*Total*
1st year (11-12)	1483	1253	2736
2nd year (12-13)	1611	1551	3162
3rd year (13-14)	2284	1864	4148
4th year (14-15)	3116	2831	5947
5th year (15-16)	1117	904	2024
ALL YEARS	9611	8403	18014

Month in which the Questionnaire was completed

	%		%
January	9	July	9
February	4	August	0
March	11	September	2
April	3	October	19
May	6	November	5
June	16	December	16

Day of the week on which the Questionnaire was completed

	%
Tuesday	23
Wednesday	29
Thursday	27
Friday	21

Nature of catchment area

	%
Rural (100 %)	19
Rural/Suburban (75/25 %)	4
Rural/Suburban/Urban (50/40/10 %)	16
Rural/Suburban/Urban (10/50/40 %)	37
Suburban/Urban/Inner urban (40/50/10 %)	19
Urban/Inner urban (25/75 %)	2
Inner urban (100 %)	4

School lunch provision

	%
Cafeteria	54
Set lunch	8
Both	36
None	2

Percentage of children in the school being transported by school bus

	%
0-10%	37
11-20%	17
21-30%	15
31-40%	10
41-50%	7
51-60%	4
61-70%	2
71-80%	4
>80%	3

Sex of school population

	%
Male	8
Female	4
Mixed	88

Type of school

	%
Middle	3
Comprehensive	88
Grammar	2
Other	7

Percentage of ethnic-minority children in the school

	%
0-1%	57
2-5%	22
6-10%	5
11-15%	4
16-20%	4
21-30%	2
31-40%	2
41-50%	2
>50%	2

Percentage of children in the school qualifying for a free meal

	%
0-1%	15
2-5%	16
6-10%	35
11-15%	6
16-20%	8
21-30%	10
31-40%	4
41-50%	3
>50%	3

YOUNG PEOPLE AND 'ILLEGAL' DRUGS IN 1987

For several years the anxiety amongst parents, teachers, health-care professionals, the police and other bodies over the use of drugs by young people has been high. This anxiety is often heightened by reports through the media which typically draw attention to excess use, damage and disaster. In 1987 a new section on illegal drugs was added to the Health Related Behaviour Questionnaire, and a very large amount of information has now been gathered by combining all the survey data collected during that year. Because of the anxiety raised by distorted media reporting, it is most important to be able to see this 'news' in perspective if appropriate education intervention programmes are to be planned. This monograph examines the results obtained so far from the questions in this new section, and the reliability of the data.

The Health Related Behaviour Questionnaire

The Health Related Behaviour Questionnaire had its origins in the late 1970s. It was founded on the belief that if teachers and health care professionals could be reliably informed of the behaviours of young people in their 'care', courses and curricula in Health Education could be designed or modified to make them more relevant to current needs. The function of the questionnaire is therefore to assist curriculum planning in secondary schools and colleges. It was developed in consultation with teachers and health-care professionals and is continually being revised.

A school, or (as is happening more frequently) a group of schools, enquires about the use of the questionnaire. A master is sent to the school for photocopying, with a guide to using and supervising the questionnaire. For group studies a member of the Unit staff is often able to go and introduce the questionnaire at a seminar, allowing teachers to clarify and discuss its supervision and use.

It has been found that the atmosphere in which the questionnaire is administered is the most significant factor in obtaining truthful responses. If a pupil believes that the data collected is important and will beneficially affect their school curriculum, and also that the completed questionnaire is confidential, then the responses are honest. Therefore it is vital that the teacher supervising the session fully explains the situation to the pupils and sets the right atmosphere.

The completed questionnaires are then sent to the Unit where they are coded and keyed into the computer. The data is retuned to the schools in tabular form, usually in 4–6 weeks. Information booklets about the data are provided in order to help teachers interpret the tables.

The 1987 databank

The results described here were obtained from the newest version of the Health Related Behaviour Questionnaire, Version 11D, which was adopted in the summer of 1987 and contained our trial section of 'illegal drugs' questions. A description of the national sample of 18,014 pupils begins on page 4. Although this sample is not a deliberately controlled or 'random' one, the great majority of this very large number of respondents are in comprehensive schools, which in many communities are themselves closely representative of the national socio-economic profile. Attention must be drawn to the fact that the level of confidence in the validity of answers to questions throughout the questionnaire is variable. The confidence would be least to answers to the newest questions. This variation is related to:

1. Is the question attitudinal or behavioural?
2. On what span of memory does the question depend?
3. For how long has the question been present in the series of questionnaires? (Hence, how much information have we gained from interview work and reported evidence from teachers who are responsible for collecting the data and using it in the classroom after it has been returned to the school? Returning data to the respondents who provided it is a unique feature of this survey work, and must have considerable significance in the overall validity of the methodology.)
4. How do the summarised data from responses to the question compare with information derived from similar questions in such surveys as the OPCS?
5. How much evidence have we from the previous use of the question in the annual data banks from 1982 onwards?

The evidence that the alcohol statistics are reliable and valid is strong. Similarly the data on smoking behaviour stands up to scrutiny and comparison with other survey work. The reported levels of use of self-medication and prescribed medicines stand up to the tests we apply. With respect to the illegal drugs questions, however, the validity is still under review.

This monograph examines summarised data from the responses of these 18,000 boys and girls aged 11 to 16 years to three of the newly-incorporated drugs questions, namely :

How many of your friends do you think take any of these drugs?

Have you ever been offered any of these drugs?

Have you ever used any of these drugs?

The list of drugs to which they were referred included amphetamines, barbiturates, cannabis leaf, cannabis oil, cocaine, natural hallucinogens, synthetic hallucinogens, heroin, solvents, and tranquillisers — the form of the checklist is shown in Fig. 1. The attempt is made in the parentheses to give 'street' names for the substances in order to assist in the accurate identification of the drugs, but to accommodate local variation of slang

names several coordinators of surveys have sensibly substituted names currently used in their locality at the time of their survey.

Levels of exposure to 'illegal' drugs

Table 1 displays the responses to Question 70 — *How many of your friends do you think take any of the drugs listed in Question 67?*: the results are modified to show only those who think they know one or more 'users'.

A Amphetamines (e.g. speed, stimulants, uppers)
B Barbiturates (e.g. barbies, bombers, downers, nembutal, seconal, sleepers)
C Cannabis (leaf form, e.g. grass, hash, marijuana, pot)
D Cannabis (oil or resin, e.g. Leb black)
E Cocaine (e.g. coke, crack, snow)
F Hallucinogens (natural, e.g. liberty cap, magic mushrooms)
G Hallucinogens (synthetic, e.g. acid, angel dust, LSD)
H Heroin (e.g. H, junk, skag, smack)
I Solvents (e.g. aerosols, cleansing fluid, gas, glue, lighter fuel)
J Tranquillisers (e.g. librium, valium)
Any other *(Please write the name below)*

Fig. 1. The checklist of 'illegal' drugs as presented in the Health Related Behaviour Questionnaire, Version 11.

Drug	1st year		2nd year		3rd year		4th year		5th year	
	Boys	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
Amphetamines	0.3	0.1	0.3	0.1	0.7	0.8	1.3	1.9	3.4	4.4
Barbiturates	0.1	0.0	0.4	0.0	0.6	0.1	0.4	0.4	0.8	0.3
Cannabis (leaf)	0.4	0.3	1.1	0.5	2.6	2.7	6.0	6.3	8.1	12.3
Cannabis (oil or resin)	0.1	0.1	0.2	0.1	1.5	1.1	2.9	2.2	5.6	4.3
Cocaine	0.7	0.4	0.7	0.3	2.0	0.6	1.3	1.8	1.6	3.1
Hallucinogens (natural)	0.3	0.1	0.2	0.1	1.0	1.4	3.0	3.4	3.2	5.1
Hallucinogens (synthetic)	0.3	0.2	0.2	0.0	0.7	0.4	0.8	1.1	1.3	1.7
Heroin	1.2	0.4	1.4	0.5	1.6	1.3	1.6	2.3	2.3	3.3
Solvents	0.6	1.0	1.4	0.7	2.8	3.1	5.0	5.8	4.8	6.7
Tranquillisers	0.1	0.0	0.3	0.0	0.5	0.2	0.6	0.5	0.5	0.8
No. of respondents	1483	1253	1611	1551	2284	1864	3116	2831	1059	904

Table 1. The percentages of boys and girls who believe they know at least one drugs user. The figures were derived from responses to Question 70: *How many of your friends do you think take any of the drugs listed in Question 67?*

Drug	1st year		2nd year		3rd year		4th year		5th year	
	Boys	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
Amphetamines	0.1	0.1	0.0	0.0	0.5	0.5	1.2	1.2	3.3	3.4
Barbiturates	0.0	0.0	0.0	0.1	0.2	0.1	0.3	0.5	0.5	0.8
Cannabis (leaf)	0.3	0.2	1.3	0.6	2.2	1.6	4.5	4.6	8.6	8.3
Cannabis (oil or resin)	0.4	0.2	0.6	0.1	1.3	0.9	2.4	2.1	4.8	1.7
Cocaine	0.5	0.4	0.8	0.5	1.4	0.6	1.1	1.5	2.2	1.8
Hallucinogens (natural)	0.1	0.0	0.4	0.0	0.6	0.7	1.5	2.0	1.9	2.4
Hallucinogens (synthetic)	0.2	0.1	0.2	0.0	0.5	0.6	0.9	0.6	1.5	1.5
Heroin	0.7	0.4	1.4	0.5	1.8	1.3	1.9	2.1	3.4	1.9
Solvents	0.6	0.0	0.7	0.5	1.6	2.0	2.7	2.6	2.3	2.7
Tranquillisers	0.0	0.0	0.3	0.0	0.2	0.2	0.4	0.5	0.8	0.4
No. of respondents	1483	1253	1611	1551	2284	1864	3116	2831	1059	904

Table 2. The percentages of boys and girls reporting that they had been offered any of the drugs in the checklist.

Since it is quite likely that several respondents could know the same 'user', we should be careful not to misinterpret the data by regarding it as an indication of the number of users. However, since this information does not imply a direct connection between the respondent and illegal drug use, it is particularly useful in gauging the level of contact of boys and girls with the presence of illegal drugs. It might in fact be one of the most reliable questions if honesty in reporting is a problem.

Table 2 displays responses to Question 69 — *Have you ever been offered any of the drugs listed in Question 67?*, while Table 3 displays responses to Question 68 — *Have you ever used any of the above drugs except on a doctor's prescription?* Table 4, which has been created by extracting detail from Tables 2 and 3, contains the data concerned with the drug which is most frequently reported as a part of their experience, namely cannabis leaf.

One comment raised by the low levels of reported use from these large samples of young people from many different parts of the country is that the results from a few communities with high exposure to illegal drugs could be hidden amongst results from a majority of communities with minimal exposure. To illustrate this, Table 5 displays differences between six schools in neighbouring communities in one District Health Authority. The percentages of 5th–year boys and girls (15–16 year olds) reporting being offered the named drugs are shown, and the suggested differences between communities appear to be borne out, with School D exhibiting a much higher general level of drug-related behaviour.

Drug	1st year		2nd year		3rd year		4th year		5th year	
	Boys	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
Amphetamines	0.2	0.1	0.1	0.0	0.4	0.1	0.6	0.6	1.2	0.7
Barbiturates	0.0	0.0	0.1	0.1	0.4	0.2	0.2	0.3	0.1	0.2
Cannabis (leaf)	0.0	0.0	0.3	0.1	0.8	0.8	1.7	1.7	3.9	3.3
Cannabis (oil or resin)	0.0	0.0	0.1	0.0	0.5	0.3	1.0	0.9	3.6	1.0
Cocaine	0.1	0.1	0.4	0.1	0.4	0.1	0.4	0.3	0.6	0.1
Hallucinogens (natural)	0.1	0.0	0.1	0.0	0.4	0.2	1.1	0.5	1.3	0.8
Hallucinogens (synthetic)	0.0	0.0	0.0	0.0	0.3	0.1	0.4	0.2	0.6	0.3
Heroin	0.1	0.0	0.1	0.1	0.7	0.3	0.4	0.2	0.6	0.0
Solvents	0.1	0.1	0.3	0.3	1.1	1.3	1.3	2.1	2.6	2.1
Tranquillisers	0.1	0.2	0.2	0.3	0.6	0.5	0.6	1.1	0.3	1.0
No. of respondents	1483	1253	1611	1551	2284	1864	3116	2831	1059	904

Table 3. The percentages of boys and girls reporting that they had used any of the drugs in the checklist.

Exposure to cannabis	1st year		2nd year		3rd year		4th year		5th year	
	Boys	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
Been offered	0.3	0.2	1.3	0.6	2.2	1.6	4.5	4.6	8.6	8.3
Used	0.0	0.0	0.3	0.1	0.8	0.8	1.7	1.7	3.9	3.3
No. of respondents	1483	1253	1611	1551	2284	1864	3116	2831	1059	904

Table 4. The percentages of boys and girls reporting that they had been offered, or had used, the drug described as 'cannabis leaf'.

The post–16 group

Another observation is that while the general level of use by the 11–16 age range is quite low, it might change dramatically beyond this age. We have tried to address this question, but we have decided not to present data from any surveys we have supported, since whereas in the under-16 surveys all boys and girls in the communities served by the schools are represented, in the post-16 surveys only those remaining in full-time education will normally be included. This precludes an adequate reflection of exposure to drugs in the communities being served by the school or FE college.

However, a general comment on the result of our searches is that the level of exposure of young people in post-16 education is higher than the 15–16 year old levels portrayed in foregoing tables, and that this level is again higher for males than for females.

Drug	A		B		C		D		E		F	
	Boys	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
Amphetamines	2.0	2.0	2.2	3.9	9.3	7.6	20.9	12.5	12.1	2.7	2.2	8.8
Barbiturates	0.0	2.0	2.2	0.0	1.9	0.0	2.3	5.0	3.4	0.0	0.0	2.9
Cannabis (leaf)	8.0	2.0	6.5	13.7	7.4	3.0	32.6	12.5	13.8	2.7	8.7	8.8
Cannabis (oil or resin)	12.0	2.0	4.3	5.9	7.4	0.0	25.6	7.5	6.9	0.0	17.4	5.9
Cocaine	0.0	4.0	2.2	3.9	1.9	0.0	4.7	0.0	3.4	0.0	4.3	0.0
Hallucinogens (natural)	2.0	0.0	0.0	0.0	1.9	1.5	2.3	2.5	5.2	2.7	2.2	0.0
Hallucinogens (synthetic)	0.0	0.0	0.0	0.0	3.7	0.0	4.7	7.5	5.2	2.7	2.2	2.0
Heroin	2.0	0.0	0.0	3.9	7.4	1.5	0.0	5.0	5.2	0.0	0.0	0.0
Solvents	2.0	4.0	2.2	2.0	3.7	4.5	11.6	10.0	6.9	2.7	4.3	2.9
Tranquillisers	4.0	2.0	4.3	0.0	3.7	0.0	7.0	2.5	0.0	0.0	0.0	0.0
No. of respondents	50	50	46	51	54	66	43	40	58	37	46	34

Table 5. The percentage of 5th-year (15–16 year old) boys and girls in six different suburban schools (A–F) in one District Health Authority who had been offered any of the drugs in the checklist.

Smoking and cannabis

Some results presented to a meeting of ASH (Action on Smoking and Health) in April 1988, at the British Medical Association in London, are included here as Table 6. The responses to the question *Have you ever been offered cannabis leaf ?* are displayed against the respondent's smoking behaviour as indicated by another section of the Health Related Behaviour Questionnaire.

The data is from 4th-year boys and girls (14–15 years old). The differences in level of exposure to cannabis use across the five 'smoking'

'Smoking' status	*Boys*	*Girls*
Never started	1.8%	0.9%
Tried just once or twice	3.5%	1.6%
Given up	8.9%	5.7%
Smoke and would like to stop	15.8%	14.7%
Smoke and don't want to stop	21.0%	24.1%
No. of respondents	2873	2631

Table 6. Exposure to drugs for 4th-year boys and girls according to their 'smoking' status. These respondents stated that they had been offered cannabis in leaf form.

categories are clear: a greater percentage of the more positive smokers have been offered cannabis. It should also be noted that, in keeping with the findings of other surveys, there are more girls than boys smoking in this age group.

A VULNERABLE NATIONAL RESOURCE FOR DRUG EDUCATION

The ESG Drugs Advisory Teachers have brought great vigour and purpose to an important aspect of health education and health promotion in schools, sixth-form colleges, and colleges of FE across the country. Therefore, concern must be expressed here that with the anticipated ending of the support funding the level of understanding and expertise that has been developed will be lost, even though the urgency of the problems being tackled will be present this year, next year, and in the foreseeable future. Drugs Advisory Teachers have been instrumental in:

1. *Bringing health education groups together.*
2. *Returning health education to the client (i.e., the young person).*
3. *Building a national team of highly-trained professionals working on a co-operative basis, both nationally and regionally, with a vigour and common philosophy.*
4. *Stimulating enthusiasm by encouraging an 'open door' approach linked to a high level of creativity.*
5. *Encouraging a national approach to drugs education within health education.*

Irrespective of who does the work, the expertise now exists to support it.

The existence of the ESG has already created demands for insights and training in the light of social needs more broadly based than health alone. Is the country, therefore, about to lose a resource developed through the Education Support Grant now that the members of this resource have been trained and equipped? I have yet to meet one of their number who has a continuing appointment in the same post or has found one very similar to it.

Is it too late to save this currently well-co-ordinated national resource?

YOUNG PEOPLE AND 'LEGAL' DRUGS IN 1987

In an earlier monograph entitled *Alcohol consumption and alcohol-related behaviour in young people*, attention was focussed on the consumption of alcoholic drinks by young people in the years 1984–1986. Alcohol is not usually brought to mind when the subject of young people and drugs is raised, but there is danger in singling out particular drugs as 'illegal' (implying that they are more potent or dangerous) if this allows the 'legal' or socially-acceptable drugs to arouse less concern. After all, demonstrably more social damage is caused by misuse of alcohol, tobacco, and prescribed drugs than by all the 'illegal' drugs multiplied many times. Therefore a brief mention of data referring to the use of some 'legal' drugs in 1987 will be made here.

Fig. 2 shows our 1987 data on the percentage of boys and girls consuming different named **alcoholic beverages**. This extends the information already published for 1986. No obvious differences will be noted if the previous monograph is studied, but it should be remarked that the consumption of spirits amongst the 5th-formers (age 15–16) was higher for the girls than for the boys for the second year running. The popularity of fortified wine (especially vermouth) as a girls' drink is again marked.

In Fig. 3 will be found information about the sources of alcohol used by young people, and the following conclusions may be made:

1. Home was the major source, the percentage increasing with age from 24% to 35% for the boys and from 18% to 30% for the girls.
2. For both sexes the pub jumps in importance as a source of alcoholic drinks in the 5th year (age 15–16), with 27% of the boys and 25% of the girls saying that they had obtained alcoholic drink from a pub or bar during the past week.
3. The use of supermarkets and off-licences as sources of alcoholic drink is noticeable. In the 5th year, 20% of the boys and 10% of the girls used an off-licence during the past week.
4. The higher percentage of 5th-year girls (24%) than boys (19%) who used a disco or party as a source of alcohol reflects the higher attendance of girls in this age-group at these functions, the boys tending to be older. Examining the data for visits to a disco in the past week (16% of boys and 31% of girls in the 5th year), and allowing for the extra proportion who went to a party, the large majority drinking alcohol at these events is obvious.

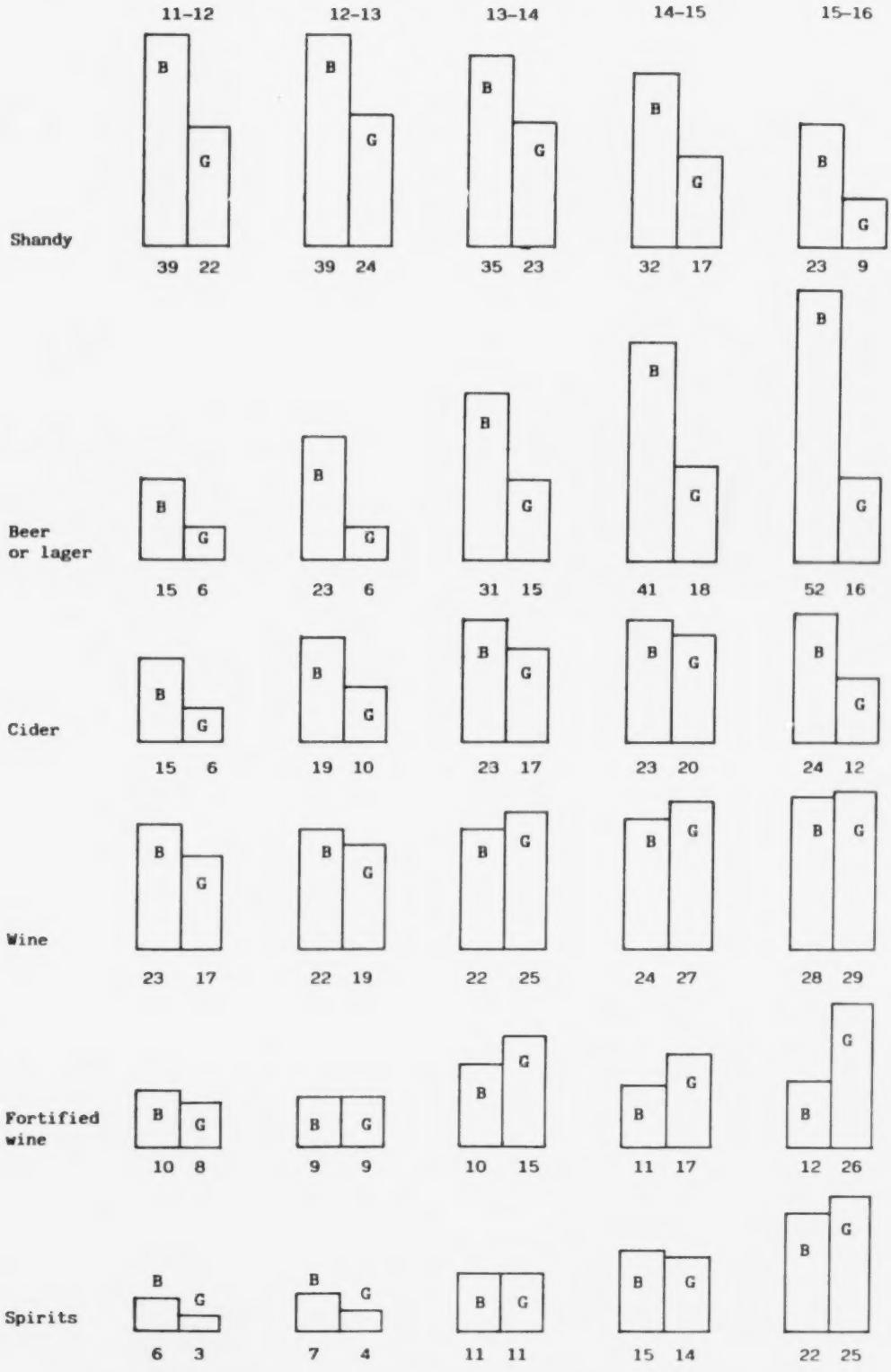


Fig. 2. The percentage of boys (B) and girls (G) in each year group who consumed any of the different named alcoholic drinks during the previous seven days. (1987 data.)

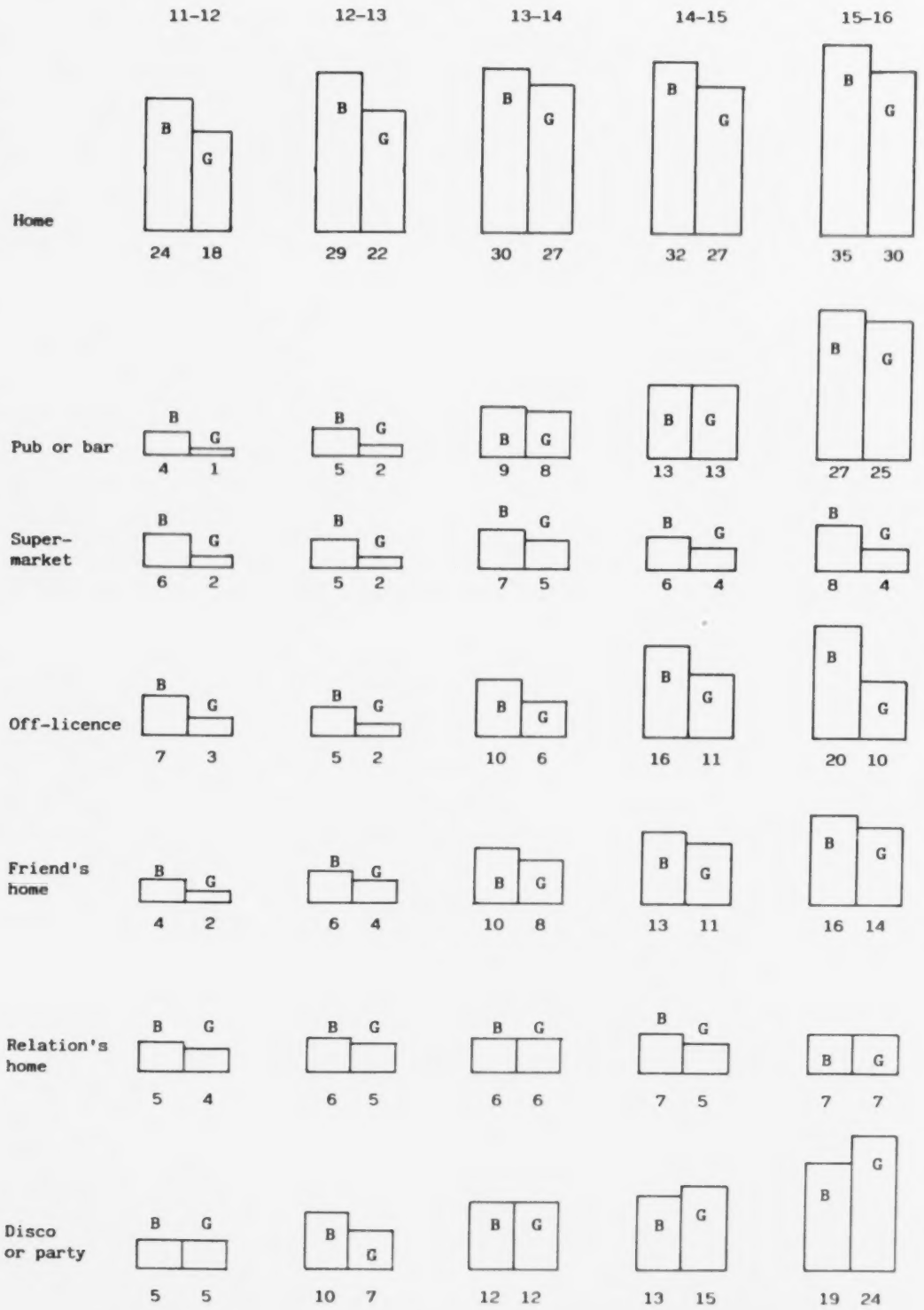


Fig. 3. The percentage of boys (B) and girls (G) in each year group who obtained alcoholic drink from any of the named sources during the previous seven days. (1987 data.)

The use of **painkillers** is another aspect of 'legal drugs' which could cause concern. Table 7 presents information taken from the 1987 databank, and shows that 37% of 1st-year boys (age 11–12) and 45% of 1st-year girls had taken a painkiller during the past two weeks. The great majority of these must have been non-prescribed, since another question discovers that only about 4% of boys and girls in each year group were using painkillers under doctor's orders. This prompts the question: what about still younger children, and who is responsible for such widespread use of these drugs?

Table 8 displays the use of non-prescribed medicines or pills, which may be considered to come under the heading of 'legal' drugs. It shows how over the years of secondary schooling the responsibility for taking them shifts from 17% of 1st-year boys to 51% of those in the 5th year, and for girls in the same age range from 15% to 58%. Are these levels of independence over drug use acceptable?

	1st year		2nd year		3rd year		4th year		5th year	
Drug	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
In past week	23.1	30.0	26.4	33.0	26.0	38.3	27.5	42.5	25.6	43.4
In past 2 weeks	13.5	14.8	13.5	13.4	11.0	15.5	12.9	15.1	11.7	16.2
In past month	16.9	20.4	20.9	20.9	21.4	20.2	21.6	20.8	19.3	19.7
In last 3 months	16.6	11.0	13.6	11.5	15.0	10.0	13.4	8.3	17.3	7.7
3+ months ago	29.9	23.9	25.6	21.2	26.6	16.0	24.6	13.2	26.1	13.1
No. of respondents	1483	1253	1611	1551	2284	1864	3116	2831	1059	904

Table 7. The percentages of boys and girls who responded to Question 34: *When did you last use aspirin, paracetamol, or other similar pain-killer?*

	1st year		2nd year		3rd year		4th year		5th year	
Drug	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
You did	17.4	15.2	23.4	18.3	31.3	35.6	40.8	44.7	51.1	58.0
Others did	82.6	84.8	76.6	81.7	68.7	64.4	59.2	55.3	48.9	42.0
No. of respondents	1483	1253	1611	1551	2284	1864	3116	2831	1059	904

Table 8. The percentages of boys and girls who responded to Question 35: *When you last took medicine or pills that were not on doctor's orders, who decided that you should do so?*

VALIDATION

(This updated extract from the introduction to 'Mayfly', a study of a group of 4th-year pupils who answered the Health Related Behaviour Questionnaire in May 1983, further illustrates the problem of 'honesty' referred to on page 3.)

Any questionnaire study automatically invites the question: *How do you know if they are telling the truth?* There is no simple answer, since the question itself is not as simple as it may seem. In fact, there are at least four aspects to be considered when studying the validity of the responses.

1. *Is the question clear?* The respondent must know what information is being sought. Errors result from (*a*) not understanding and (*b*) misunderstanding. The cause of (*a*) may be inappropriate language, or the use of an unfamiliar concept. Careless phrasing may cause (*b*). Much of the preliminary fieldwork with the numerous versions of the Health Related Behaviour Questionnaire concerned such problems. One obvious difficulty is to produce a single document appropriate both in content and in language for individuals across the age range 11 to 16+.

2. *Is an accurate answer possible?* Some questions are answered 'Yes' or 'No'. Others are less straightforward. For example, one question asks *What time did you get up this morning?* The respondent, having decided upon the answer (which itself may be subject to inaccuracies), writes down the time, but unless it happens to be an exact hour or half-hour it will not appear at this value in the printout, since all answers have to be grouped into 30-minute blocks to give a manageable number of columns in the printed table. A loss of accuracy is therefore likely.

Sometimes, answering can be helped by grouping the available answers into categories, especially when a scientifically 'accurate' answer is not possible. A good example is *How long did you spend doing homework last night?*: what does 'doing homework' mean, and how likely is it that the beginning and finishing times were noted? Therefore it simplifies the respondent's task, without reducing the likely accuracy, by offering a block of answers: *None, Up to 1 hour, Up to 2 hours*, etc. Yet someone indicating *Up to 1 hour* could have spent five minutes or sixty minutes doing homework. Does this large range matter? Should we work in half-hour steps? Such questions are always open to debate.

Even more problematical are those questions which relate to habit rather than to specific instance. Let us consider *Do you wash your hands after visiting the lavatory?* If the answer space were left to be filled in, a whole range of replies could be expected, many of which could be useful and interesting, but would have to be coded into a fixed set of categories. This would slow down the expensive coding work, and could create difficulties if an unusual answer defied all normal categories! Therefore, the question

allows only the three answers *Never*, *Sometimes*, and *Whenever possible*, in the hope that these cover the range of possible answers.

3. *Is the question valid?* Some questions require information of a factual kind, which the child may not know, or may have forgotten. An example of the former is the enquiry into inoculations received — many adults, as well as children, are vague or ignorant on this topic. (This does not necessarily invalidate the question altogether, since this vagueness may be illuminating; but it turns it into a different type of question.) Questions involving an effort of memory, such as the time interval since the last visit to a doctor or dentist, may become less reliable as the interval increases.

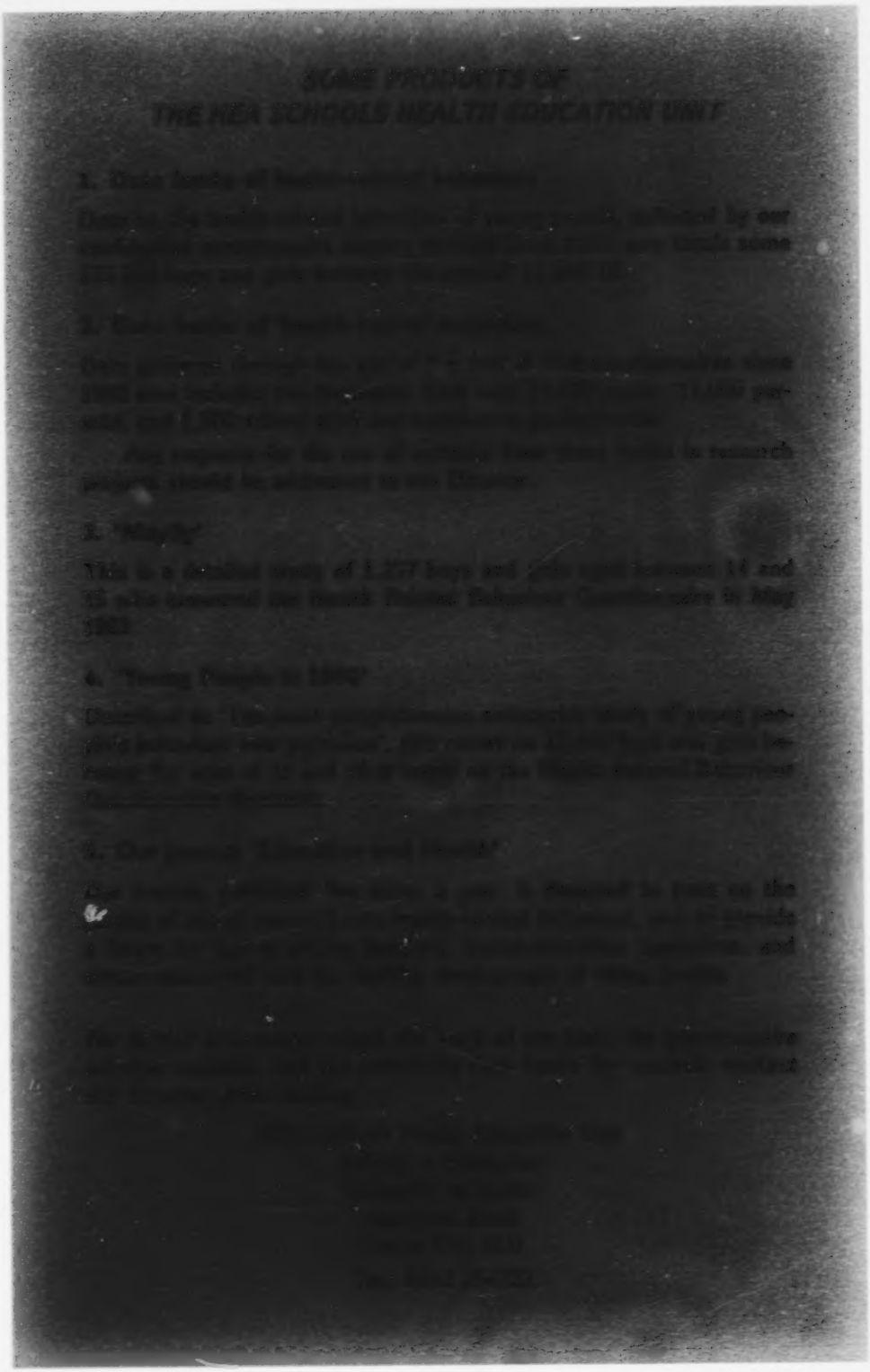
4. *Is the respondent sincere?* Assuming that the question is so well written that its purpose is obvious, and that it is possible for the respondent to give a satisfactory answer, the validity of the response still depends upon the sincerity of the person completing the questionnaire. The aim could be

(*a*) To be as honest as possible;
(*b*) To please, and give the 'expected' answer;
(*c*) To frustrate the enquiry by giving a wrong answer;
(*d*) To annoy or shock by giving an absurd or offensive answer.

There are two ways of examining this factor.

Follow-up interviews On several occasions, a questionnaire study has been run by a school in the normal way, and then followed up by interviews by experienced teachers independent of the Unit, or by members of the Unit. Some 80 individuals have been involved in this work, checking the pupils' understanding of the questions and the validity of their answers, and these interviews have been valuable in highlighting the different aspects outlined in this section. These studies have, incidentally, revealed a statistically insignificant degree of questionnaire abuse.

Internal consistency The questionnaire does contain some questions which relate closely to each other, even though they are not located together. For example, two adjacent questions on smoking habits can be studied in the light of another question many pages away on spending money on cigarettes. Typically, the answers to one are consistent with and predictive of the answers to the other. A number of other cross-checks may be made. It is also found that the range of responses to particular questions support a 'reasonable' interpretation: we do not find a significant group of children claiming to have drunk unlikely amounts of alcohol or to have smoked an extraordinary number of cigarettes. Perhaps some are following a policy of concealment, as in (*b*) above, just as some others may be determined to exaggerate? Undoubtedly this does happen, but the evidence of linked behaviours and cross-checks suggests that these individuals form an insignificant minority.



END

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